ASTHMA

Mamaroneck Union Free School District

EMERGENCY ACTION PLAN

Student's name: _____ DOB: _____ Grade/class: _____

School: ❒ Central ❒ Chatsworth ❒ Mamaroneck Avenue ❒ Murray ❒ Hommocks ❒ High School ❒ Other _____

Mother/Guardian: _____ (H) _____

(C): _____ (W) _____

Father/Guardian: _____ (H) _____

(C): _____ (W) _____

Emergency Contact:

_____ (H) _____

(C): _____ (W) _____

PHOTO ID

Asthma Physician: _____ Phone: _____

Primary Care physician: _____ Phone: _____

Signs of an asthma attack include:

- ✓ difficulty catching breath; chest tightness; chest hurts
- ✓ itchy chin or neck; neck feels funny
- ✓ difficulty breathing; rapid breathing
- ✓ child is hunched over to breathe
- ✓ lips or fingernails turn blue or gray
- ✓ coughing or wheezing
- ✓ child appears restless or anxious
- ✓ chest or neck pulled in with breathing
- ✓ stops activity and sits still

THE SEVERITY OF SYMPTOMS CAN QUICKLY CHANGE. ALL ABOVE SYMPTOMS CAN POTENTIALLY PROGRESS TO A LIFE-THREATENING SITUATION!

ACTION:

1. Call school nurse or administration if the school nurse is not available.
2. If an asthma attack is suspected, give inhaler or assist self-directed student to administer his/her own inhaler.
3. Nebulizer treatments can only be administered by the school nurse
4. Monitor for symptoms

IF SYMPTOMS WORSEN:

5. Do not leave student alone.
6. Call 911.
7. Call parent or guardian.
8. Inform building administration that 911 has been called.
9. Keep the student calm.

Emergency Asthma Medications:

Name of student's inhaler medication: _____ Administer 2 puffs/inhalations as ordered by Healthcare Provider

❒ Check here if a spacer is used with metered dose inhaler

Comments/Special Instructions: _____

Signature of parent/guardian: _____ Date: _____

Signature of Health Care Provider: _____ Date: _____

Parent signature gives permission to speak to child's physician/practitioner and school staff as needed

PARENT – PLEASE COMPLETE THE OTHER SIDE OF FORM

Updated: 4/16

ASTHMA INFORMATION FORM

Dear Parent(s) or Guardian(s):

Please complete the attached information form and return it to the Health Office as soon as possible. If any changes occur during the school year, please notify the school nurse.

Name of child:_____ Grade/class:_____

Daily Asthma Management Plan

D Identify the asthma triggers that apply to your child:

- O Exercise
- O Strong odors or fumes
- O Molds
- O Animals
- O Carpets in the room
- O Pollens
- O Change in temperature
- O Respiratory infections
- O Food: _____
- O Other: _____

D Describe the types of symptoms your child experiences (e.g. wheezing, coughing, tightness, other):

_____.

D What usually helps if your child has an asthma exacerbation?_____.

D Medications your child takes at home for asthma:

Name	Dose	How often
_____	_____	_____
_____	_____	_____
_____	_____	_____

D Side effects of medication that your child experiences:_____.

D Does your child use a peak flow meter? O Yes O No

If so, what is the child's current best peak flow? _____

D Number of times child has had to be taken to an emergency facility for an acute asthma exacerbation in the past 12 months: _____

D Additional information/instructions: _____

Signature of parent/guardian:_____ Date: _____

ASTHMA INHALERS AT SCHOOL:

The student comes to the health office where the inhaler is kept, and uses it under supervision. The advantage is that the medication will be used correctly, in the proper amount, and records will be kept. A number of students keep their inhalers in the health office and come in before PE, recess, or as needed. Students who are Independent may carry their own inhalers. Students at the elementary level must keep an additional inhaler in the Health Office.

All medications brought to school must be accompanied by a written doctor's order, with a signed parental permission note. The medication must be in its original container, clearly labeled from your pharmacist. Forms are available from the school nurse.

PLEASE COMPLETE THE OTHER SIDE OF FORM

MAMARONECK UNION FREE SCHOOL DISTRICT

ASTHMA/ MDI Medication Permission Sheet
at School/School - Sponsored Events

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/Counselor_____ School: _____

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take his/her own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____
Parent/Guardian Signature **Date**

_____ _____
Email **Phone Where We Can Reach You** ☐ **Check if Cell**

Parent signature gives permission to speak to student's physician/ practitioner and school staff as needed

To Be Completed By Health Care Provider-Valid for School Year

Diagnosis: Asthma _____

Medication: _____**MDI**

Dose: 2 puffs Q ____ hours **Route: Inhaled** **Time: PRN**

Recommendations: Administer for cough, wheeze, dyspnea, SOB, chest tightness
Use Spacer if Provided

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**
NYS law requires both provider attestation that the student has demonstrated he/she can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____ Stamp
Name/Title of Prescriber (Please Print) **Date**

_____ _____
Prescriber's Signature **Phone**

PLEASE RETURN TO THE SCHOOL NURSE

MAMARONECK UNION FREE SCHOOL DISTRICT

ASTHMA/Nebulizer Medication Permission Sheet

at School/School - Sponsored Events

To Be Completed By Parent

Student Name: _____ DOB: _____

Grade: _____ Teacher/Counselor_____ School: _____

I request the school nurse give the medication listed on this plan; trained staff may assist my child to take his/her own medications. I will provide the medication in the original pharmacy or over the counter container. This plan will be shared with school staff caring for my child.

_____ _____

Parent/Guardian Signature **Date**

_____ _____ ☐ Check if Cell

Email **Phone Where We Can Reach You**

Parent signature gives permission to speak to student's physician/ practitioner and school staff as needed

To Be Completed By Health Care Provider-Valid for School Year

Diagnosis: Asthma _____

Medication: _____**Inhalation Solution**

Dose: _____**mg /3ml; (1 unit dose)** **Route: Via Nebulizer with mask or pipe** **Time: Q**_____**hrs. PRN**

Recommendations: Administer for cough, wheeze, dyspnea, SOB, chest tightness

☐ **Independent Carry and Use Attestation Attached (Required for Independent Carry and Use)**

NYS law requires both provider attestation that the student has demonstrated he/she can effectively self- administer inhaled respiratory rescue medications, epinephrine auto-injector, Insulin, glucagon and diabetes supplies or other medications which require rapid administration along with parent/guardian permission delivery to allow this option in school. Check this box and attach the attestation to this form to request this option.

_____ _____ Stamp

Name/Title of Prescriber (Please Print) **Date**

_____ _____

Prescriber's Signature **Phone**

PLEASE RETURN TO THE SCHOOL NURSE

MAMARONECK UNION FREE SCHOOL DISTRICT

ATTESTATION AND PARENT PERMISSION
REQUIRED FOR INDEPENDENT MEDICATION CARRY AND USE

Directions for the Health Care Provider: This form must be used as an addendum to a medication permission sheet, it is an attestation for a student to independently carry and use his/her medication as required by NYS law. A **provider order** and **parent/guardian permission** are needed in order for a student to carry and use medications that require rapid administration to prevent negative health outcomes. These medications should be identified by checking the appropriate boxes below.

Student Name: _____ **DOB:** _____

Health Care Provider Permission for Independent Use and Carry

I attest that this student has demonstrated to me that he/she can self-administer the medication(s) listed below safely and effectively, and may carry and use this medication (with a delivery device if needed) independently at any school/school- sponsored activity. Staff intervention and support is needed only during an emergency. This order applies to the medications checked below:

This student is diagnosed with:

- ☐ Allergy and requires Epinephrine Auto-injector
- ☐ Allergy and requires Antihistamine
- ☐ Asthma or respiratory condition and requires Inhaled Respiratory Rescue Medication
- ☐ Diabetes and requires Insulin/Glucagon/Diabetes Supplies
- ☐ _____ (State Diagnosis) which requires rapid administration of _____ (Medication Name)

Signature: _____ Date: _____

Parent/Guardian Permission for Independent Use and Carry

I agree that my child can use his/her medication effectively and may carry and use this medication independently at any school/school-sponsored activity. Staff intervention and support is needed only during an emergency.

Signature: _____ Date: _____

STAMP

PLEASE RETURN TO THE SCHOOL NURSE

MAMARONECK

PUBLIC SCHOOLS

1000 W. Boston Post Rd.

Mamaroneck NY 10543

914-220-3000

CONSENT TO RELEASE MEDICAL INFORMATION

School: Central ❍ Chatsworth ❍ Mamaroneck Avenue ❍ Murray
❍ Hommocks ❍ High ❍ Other _____

Date: _____

Name of physician/practitioner: _____
Street Address: _____
City/Town; State; Zip: _____
Phone: _____

Name of student: _____
Date of birth: _____

To: Physician/practitioner

Please release any medical documentation and/or other information on the above named patient to the school nurse, and/or the school physician as maybe requested by a representative of the District's Health Office.

_____ _____
Parent's signature Date

PARENT SIGNATURE DENOTES PERMISSION TO SHARE INFORMATION WITH STAFF ON A NEED-TO-KNOW BASIS.